APPENDIX 3

BELLSOUTH OPEB EXOGENOUS COST CHANGE
SUMMARY FOR THE ANNUAL PERIOD 1993
($000)

REVENUE EFFECT

	CL	SW	SP	IX	TOTAL
DEPR EXP	80	42	17	0	139
EXP LESS DEPR	424	247	103	4	778
TAXES LESS FIT	(1)	0	0	0	(1)
NET RETURN	(13)	(4)	(2)	0	(19)
FIT	(7)	(2)	(1)	0	(10)
UNCOLL REV & OTH ADJ	0	0	0	0	0
REV EFFECTS	483	283	117	4	887
EXOGENOUS IMPACT @ 84.8%	410	240	99	3	752

RATE BASE EFFECT

	CL	SW	SP	IX	TOTAL
TOT PLT IN SVC	1,130	560	243	0	1,953
OTH RATE BASE	(1,254)	(644)	(271)	0	(2,169)
DEPR RESERVE	41	22	8	0	71
DEF INC TAX	(51)	(53)	(19)	0	(123)
NET RATE BASE	(114)	(33)	(17)	0	(164)

APPENDIX 4

EXCEPTS FROM BELLSOUTH'S 1991 ANNUAL REPORT

Postretirement Benefits Other Than Pensions. BellSouth also provides certain health care and life insurance benefits to substantially all employees that retire from BellSouth eligible for a service or disability pension benefit. The cost of providing health care and life insurance benefits for both active and retired employees was $550.6, $503.0 and $483.8 in 1991, 1990 and 1989, respectively. Included in these costs were $165.3, $153.2 and $84.8 in 1991, 1990 and 1989, respectively, for postretirement health care benefits other than those provided on a pay-as-you-go basis. At December 31, 1991, there were approximately 39,500 retirees and 96,100 active employees eligible to receive these benefits.

During 1989, the costs of providing postretirement health care benefits were accrued and funded over the working lives of active employees. Certain retiree benefits, however, were recognized on a pay-as-you-go basis. Beginning in 1990, BellSouth began to accrue and fund for both active and retired employees represented under the collective bargaining agreement into a separate tax advantaged trust. These contributions are funded over the working lives of active employees and the remaining lives of the retirees. Costs for nonrepresented employees continue to be accrued and funded as in 1989. Postretirement life insurance benefit costs are accrued and funded over the working lives of active employees based on that group's historical claims experience.

In December 1990, the Financial Accounting Standards Board ("the Board") issued SFAS 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," which BellSouth is required to adopt by 1993. The statement requires employers, among other things, to accrue the cost of providing postretirement benefits other than pensions during the period employees are expected to earn the benefit.

Currently, BellSouth plans to adopt SFAS 106, effective January 1993. Because BellSouth's other postretirement benefit plans are subject to bargaining in 1992 and certain application methods have not been determined, a final estimate of the effect of implementing SFAS 106 on the statement of position and operations is not available. However, BellSouth anticipates that the transition benefit obligation will be between $1.4 and $2.0 billion, while the postretirement expense is expected to be less than two times the projected 1993 expense under the current accounting method. Since BellSouth is primarily regulated, the effect on the financial statements will depend on the ratemaking treatment authorized.

OTHER MATTERS

Accounting Pronouncements. In December 1990, the Financial Accounting Standards Board issued SFAS 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions," which BellSouth is required to adopt by 1993. The statement requires employers, among other things, to accrue the cost of providing postretirement benefits other than pensions during the period employees are expected to earn the benefit. Upon adoption, SFAS 106 permits employers the option of recognizing the unfunded and unrecognized accumulated postretirement benefit obligation (transition obligation) immediately or over the average remaining service period of active plan participants. The employer may elect a 20-year amortization period if the average remaining service period is shorter.

Currently, BellSouth plans to adopt SFAS 106 effective January 1993. Because BellSouth's other postretirement benefit plans are subject to bargaining in 1992 and certain application methods have not been determined, a final estimate of the effect of implementing SFAS 106 on the statement of position and operations is not available. However, BellSouth anticipates that the transition benefit obligation will be between $1.4 and $2.0 billion, while the postretirement expense is expected to be less than two times the projected 1993 expense under the current accounting method. Since BellSouth is primarily regulated, the effect on income will depend on the ratemaking treatment authorized.

APPENDIX 5

THE BELLSOUTH MEDICAL ASSISTANCE PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 1990

FOR BELLSOUTH PARTICIPATING COMPANIES

GENERAL CORRESPONDENCE ADDRESS:
Blue Cross and Blue Shield
BellSouth Dedicated Service Center
Post Office Box 830279
Birmingham, Alabama 35283-0279

ERISA APPEALS ADDRESS:
BellSouth Appeals Coordinator
Blue Cross and Blue Shield
Post Office Box 13126
Birmingham, Alabama 35202-3126

FOR INFORMATION RELATING TO:

Coverage and Claim Payments
Call 1-800-292-8802

Forms, Duplicate Claim Reports and Duplicate ID Cards
Call 1-800-633-8915

Eligibility
Call your Benefit Office (see pages 101-102 for telephone numbers)

FOR INFORMATION RELATING TO THE QUALITY CARE PROGRAM:

Call 1-800-541-2234

Correspondence Address
United HealthCare, Inc.
1575 Northside Drive
200 Atlanta Technology Center
Suite 100
Atlanta, Georgia 30318

FOR INFORMATION RELATING TO THE MAIL ORDER PRESCRIPTION DRUG PROGRAM:

Call 1-800-824-6349

Correspondence Address
Baxter Healthcare Corporation
Prescription Service Division
625 Barclay Boulevard
Lincolnshire, Illinois 60069

PARTICIPATING COMPANIES

The Medical Assistance Plan is available to the following Companies (referred to in this booklet as the "Company" or "Participating Company") who are eligible for coverage under this Plan:

BellSouth Advertising & Publishing Corporation
BellSouth Communications, Inc.
BellSouth Corporation
BellSouth D.C., Inc.
BellSouth Enterprises, Inc.
BellSouth Financial Services Corporation
BellSouth Human Resources Administration, Inc.
BellSouth Information Systems, Inc.
BellSouth International, Inc.
BellSouth Mobility Inc
BellSouth Resources, Inc.
BellSouth Services Incorporated
South Central Bell Telephone Company
Southern Bell Telephone and Telegraph Company
Sunlink Corporation

This list of Participating Companies may be changed from time to time. You may contact your Benefit Office if you have any questions about whether your employer is a Participating Company.

INTRODUCTION

The Medical Assistance Plan, as revised effective January 1, 1990, is designed to help protect you against financial hardship if you or a covered family member require medical attention. It does this by helping you pay for medically necessary care or treatment.

There are special features within the Medical Assistance Plan which require you and your covered dependents to make certain choices about how and where to seek medical care. These features include the Quality Care Program and BellSouth Preferred Provider Organization of hospitals, physicians and pharmacies. By using these special features, you can receive maximum Plan benefits. So, it is important that you and your family learn about these provisions. Read this booklet carefully and keep it for future reference. But remember, any decision as to appropriate medical treatment for you or your covered dependents must be made by you and your doctor.

This booklet provides the Summary Plan Description (SPD) of the Medical Assistance Plan which is referred to in this booklet as "MAP" or simply the "Plan". It is intended to explain only the major provisions of the Plan as of January 1, 1990. If there ever should be a conflict between this booklet and the contracts and documents which control the Plan, the contracts and documents will govern in all cases.

Eligibility for, or participation in, the Plan does not constitute a guarantee of employment, nor does it interfere with the Company's right to terminate employment.

BellSouth currently intends to continue the Medical Assistance Plan as described in this booklet, but reserves the right, in its discretion, to amend, reduce or terminate the Plan and coverage at any time for active employees, retirees, former employees, and all dependents, subject to any applicable collective bargaining agreements.

BellSouth will update this booklet periodically to describe changes in the Plan, but there may be a delay between the effective date of a Plan change and the date you receive a description of the change. You should contact Blue Cross and Blue Shield if you have any questions about coverage before you incur expenses for non-emergency treatment.

CONTENTS

SECTION 1. TO HELP YOU UNDERSTAND

Some words or phrases used in this booklet may not be familiar to you. However, these words or phrases have a very specific meaning as applied to the Medical Assistance Plan (MAP). To help you understand how MAP works, it's important that you know what the following terms mean as used in this booklet.

Alternate Benefits. The term used to refer to certain expenses covered by MAP only when they are pre-certified by the Quality Care Program. Alternate Benefits are designed to provide you with options to hospital stays and other medical care or treatments including coverage for:

- Birthing centers/nurse midwives;
- Extended care/skilled nursing facilities;
- Home health care;
- Hospice care;
- Partial hospitalization for a substance abuse rehabilitation program; and
- Expenses due to special arrangements or treatments when medically appropriate.

Ambulatory Surgical Facility. An institution, either free-standing or a part of a hospital, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures where a patient is admitted and discharged within a brief period (generally not to exceed 24 hours).

The following are not considered ambulatory surgical facilities:

- An office maintained by a physician or group of physicians for the practice of medicine or a surgical suite as part of their office;

- An office maintained for the practice of dentistry; or
- A facility primarily engaged in performing abortions.

Birthing Centers. A facility for the normal delivery of a child or children, operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Claims Administrator. An organization that processes medical claims at the request of the Company. The Claims Administrator for MAP is Blue Cross and Blue Shield.

Claims Report. A statement provided to the participant by Blue Cross and Blue Shield with respect to a claim which includes information such as what expenses MAP:

- Covers;
- Applies the deductible to; and
- Pays or excludes.

Many medical plans refer to this report as an Explanation of Benefits or EOB.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, signed into federal law April 7, 1986. COBRA requires that group health coverage be continued under certain circumstances when coverage would otherwise end or change. For more details, see Sections 15 through 16.

Copayment. The dollar amount that a participant pays after the deductible has been met for expenses such as PPO physician charges or Mail Order Prescription Drug Program payments.

Covered Charge/Covered Expense. The charge associated with a covered medically necessary service, supply or

procedure incurred by a participant for a non-occupational illness or injury, that is eligible for consideration based on the:

- Reasonable and customary limits;
- Payment allowance limits; or
- Negotiated fees

. . . established under MAP and not excluded by any other provision of MAP. For example, amounts above reasonable and customary limits are not covered expenses.

Deductible. Generally, the amount of covered expenses you pay during the calendar year before MAP will begin paying benefits.

The individual deductible is $165 and applies each calendar year to you and each of your covered dependents.

The family deductible will be met on the earlier of the date:

- Covered charges applied toward your deductible and/or other family members' individual deductibles total $400, or
- Two $165 individual deductibles have been met.

Dependent. A family member who qualifies for MAP coverage by meeting the following criteria:

- **Class I Dependents.** Your spouse and your unmarried children, normally living with you, until the end of the year in which they reach age 19 or until the end of the year in which they reach age 23 if full-time students, or an unmarried child who is physically or mentally handicapped and fully dependent on you for support.

  Children include your own children and legally adopted children normally living with you; stepchildren or children for whom you or your spouse are legal guardians, if they

live with you. This does not include wards of the state, foster children or custodial appointments.

If a Class I dependent child is certified as handicapped or incapacitated, he or she will continue as a Class I dependent as long as he or she qualifies as handicapped or incapacitated (regardless of age) as described on page 11.

- **Class II Dependents.** Your unmarried children (other than Class I dependents), your unmarried grandchildren, your brothers, your sisters and the parents and grandparents of you or your spouse if they have lived with you or in a household owned, leased or rented by you in the vicinity for at least six months before applying for coverage.

  Vicinity means the same town or city and zip code area as your residence or within a distance where you can provide daily care and supervision of the dependent.

  In addition, to qualify for coverage, the total income of a Class II dependent — not counting any support you provide — must be less than $7,500 ($8,800 effective January 1, 1991) from all sources, including Social Security, during the calendar year he or she is covered. A full-time student, however, who has attained age 24 or over and satisfies the income and Class II dependency requirements, does not have to live in the vicinity.

  If a Class II dependent is certified as handicapped or incapacitated, he or she will remain a Class II dependent for as long as he or she qualifies as handicapped or incapacitated (regardless of age) as described on page 11.

- **Sponsored Children.** An unmarried child, age 19 or older, who is not a full-time student. You can sponsor such a child for coverage until the end of the year in which he or she reaches age 23, whether the child resides with you or not and regardless of how much income he or she is receiving. (You pay the full cost of this coverage and you must apply for it by contacting your Benefit Office.)

Eligible Charge. Same as the definition of a covered charge/covered expense on page 2.

Emergency Admission. An admission which results from a situation that occurs unexpectedly and requires urgent and immediate medical attention to safeguard the life or health of the patient.

Employee. Any regular full-time or regular part-time employee so classified by the Company for payroll purposes. (See page 10 for a definition of retired employee.)

ERISA. The Employee Retirement Income Security Act of 1974, as amended. This act provides protections and guarantees for employees and the beneficiaries of employees covered by certain group benefit plans.

Exclusion. Service, supply, treatment, circumstance, etc. not covered under MAP.

Extended Care/Skilled Nursing Facility. An institution that provides for intermediary skilled nursing care of the chronically ill (not including custodial care).

Facility Charges. Charges billed by facilities such as hospitals or ambulatory surgical facilities as opposed to charges billed by a physician.

Generic Drug. A drug which meets the same federal standards for safety, purity, strength and quality as a brandname or trademark drug.

Home Health Care. In-home care or treatment that is provided in place of hospitalization.

Hospice Care. An institution or organization designed to provide care for the terminally ill.

Hospital. A legally constituted institution which provides 24-hour nursing services and maintains on its premises the equipment, space and supplies needed to provide diagnosis and treatment of ill or injured people by or under the supervision of a staff of physicians.

Psychiatric hospitals which are accredited by the Joint Commission on the Accreditation of Health Care Organizations are considered to be hospitals under MAP.

Convalescent homes, nursing homes and other facilities which primarily provide nursing, custodial or rest care — or care for the aged — a half-way facility, a hotel, or an institution which is a school or college infirmary, do not qualify as hospitals under MAP.

Long Term Disability (LTD) Eligible. For purposes of MAP, a former employee who is not pension eligible but is eligible to receive benefits under a Long Term Disability Plan of the Company regardless of whether LTD payments are actually being received.

Medical Assistance Plan (MAP). The BellSouth medical plan, as revised effective January 1, 1990, which also may be referred to as "MAP" or the "Plan".

Medical Expense Plan (MEP). The BellSouth medical plan, which also may be referred to as "MEP", replaced by the Medical Assistance Plan for all participants as they are defined on page 8.

Medically Necessary. A service requiring the use of a hospital, other approved medical facility, the furnishing of supplies, services performed by any provider, or any other services which are necessary to safeguard the patient's life and health or which are necessary to treat the illness or injury. To be medically necessary (as determined by Blue Cross and Blue Shield or the Quality Care Program), the services or supplies furnished must:

- Be appropriate and necessary for the symptoms, diagnosis or treatment of the participant's condition, disease, ailment or injury;
- Be provided for the diagnosis or direct care of the participant's medical condition;
- Be in accordance with standards of good medical practice accepted by the organized medical community;
- Not be solely for the convenience of the participant, his/her family, his/her physician, or another provider of services;
- Not be experimental, exploratory, or investigative; and
- Be performed or rendered where the participant's medical condition requires.

Medicare. A program sponsored by the Social Security Administration which provides benefits toward the cost of medical care for certain individuals age 65 and older, and certain disabled people under age 65.

Nurse Midwife. A person who is certified by the American College of Midwives or is licensed or certified as a nurse midwife in the states requiring such license or certification.

Partial Hospitalization. A partial hospitalization is when a patient is admitted to the hospital under an approved treatment or rehabilitation program for substance abuse and the daily stay is for less than 24 hours.

Participant. Under MAP, participant means the following individuals covered by a Participating Company under the provisions of the Plan:

- Active regular employees and their enrolled dependents;
- Regular employees on an approved Leave of Absence (other than a military leave) and their enrolled dependents;
- Former regular employees who retire on a service or disability pension and their enrolled dependents;
- Former regular employees who are LTD eligibles and not eligible for a disability or service pension and their enrolled dependents;
- Surviving spouses of deceased employees/retirees and their enrolled dependents;
- Former regular employees on Technological Displacement or layoff with extended medical coverage and their enrolled dependents; and
- COBRA-covered individuals.

Payment Allowance (PA). Limits established for non-PPO charges in each PPO area based upon the negotiated fees charged to BellSouth by the PPO providers, such as hospitals, within that area. Amounts over the payment allowances are not covered by MAP.

Physician/Surgeon. An individual who is licensed to prescribe and administer drugs or to perform surgery. Under MAP, a physician also includes the following individuals practicing within the scope of his or her license:

- Chiropractor;
- Dentist; and
- Podiatrist.

Physician also means a certified and registered psychologist when providing psychological services in connection with the diagnosis or treatment of a mental and nervous condition.

Preferred Provider Organization (PPO). A hospital, physician or pharmacy that contracts with BellSouth to provide medical services to BellSouth participants at discounted fees.

PPO Area. The geographic area which contains a network of hospitals which have agreed to provide medical services to BellSouth participants for discounted fees. You live in a PPO area if your home zip code is within 25 aerial miles of any PPO hospital. The Quality Care Program can tell you if your home zip code is in a PPO area.

If you live in a PPO area and are not Medicare eligible, you are subject to MAP's PPO provisions to obtain maximum Plan payments.

Quality Care Program (QCP). A feature of MAP designed to assist you in obtaining appropriate medical care while avoiding unnecessary medical expense. QCP is administered by United HealthCare, Inc. — an organization of independent health care professionals.

Reasonable And Customary (R&C). The fair and reasonable value of a medical procedure or service based on historical data developed from the following criteria.

A charge is "reasonable and customary" when:

- The fee is that which an individual physician or provider of medical service most frequently charges to the majority of participants for a similar service or medical procedure and which falls within the range of usual fees charged for

that service by physicians or other medical providers with similar training and experience for the performance of similar services or medical procedures within the same locality, OR

- Blue Cross and Blue Shield determines if the fees are justified because of special circumstances, or medical complications requiring additional time, skill and experience in connection with a particular service or procedure.

Reasonable and customary charges for physicians and other covered medical services, for other than services provided by hospitals, will be determined and maintained by Blue Cross and Blue Shield.

Retired Employee/Retiree. A former employee who was granted a service or disability pension by the Company under and pursuant to a BellSouth Corporation Pension Plan. (A former employee who is eligible for or who receives a deferred vested pension will not be considered a retired employee.)

Sudden/Serious Illness. An illness where there are severe symptoms which occur unexpectedly requiring immediate and urgent medical attention. Determination of sudden and serious illness will be based upon individual cases and circumstances documented to Blue Cross and Blue Shield by the medical provider of such service.

SECTION 2. ELIGIBILITY

ACTIVE EMPLOYEES

As a regular full-time or regular part-time employee of the Company, you are eligible to participate in MAP. Your dependents are also eligible for coverage provided they qualify as a dependent as defined in Section 1 and you enroll them.

RETIRED EMPLOYEES

As a retired employee, you are eligible to participate in MAP. Your dependents are also eligible for coverage provided they qualify as a dependent as defined in Section 1 and you enroll them. Refer to page 89 for more details.

DEPENDENT COVERAGE

To enroll your dependents in MAP, you must complete the Company Enrollment Form and specify your level of dependent coverage in one of the following three categories:

- Employee without dependents;
- Employee plus one dependent; or
- Employee plus two or more dependents.

Enrollment Forms are available from either your Supervisor or your Benefit Office.

No person can be enrolled as a covered employee/retiree and as a covered dependent at the same time. In addition, no person can be enrolled and covered as a dependent of more than one employee or retiree at the same time.

HANDICAPPED CHILDREN CERTIFICATION REQUIREMENTS

A handicap must be certified to the Company through your Benefit Office. The Company may request recertification of handicapped or incapacitated status annually or upon request.

SPOUSES EMPLOYED BY THE SAME BELLSOUTH COMPANY

If you and your spouse are both employees of the same Participating Company, you are both eligible for coverage under MAP and you have three options:

1. You and your spouse may each be covered as an employee. Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same month and day, your dependents must be enrolled with the older spouse;
2. You may waive employee coverage and be enrolled as a dependent under your spouse's coverage; or
3. Your spouse may waive employee coverage and be enrolled as a dependent under your coverage.

SPOUSES EMPLOYED BY DIFFERENT BELLSOUTH COMPANIES

If you and your spouse are employees of different Participating Companies and you are both eligible for coverage under MAP, you and your spouse cannot waive coverage as an employee.

Your eligible dependents must be enrolled with the spouse who has the earlier birthday (month/day) during the year. If you and your spouse were born on the same month and day, your dependents must be enrolled with the older spouse.

SPOUSES RETIRED FROM BELLSOUTH COMPANIES

If you and your spouse are both retired employees of a Participating Company, but one of you has to pay for coverage, then the one who must pay may waive coverage as a retired employee and be covered by the other as a dependent.

SECTION 3. WHEN COVERAGE STARTS

BEFORE SIX MONTHS OF SERVICE

If you are a new regular full-time or regular part-time employee, you can enroll for individual or dependent coverage within 31 days after you are hired by completing the Company Enrollment Form and paying the full cost of coverage. If you elect to pay, coverage will be effective on the first day of the month after the Company receives your Company Enrollment Form.

FOLLOWING SIX MONTHS OF SERVICE

Employees Hired Prior To March 1, 1990

If you did not enroll within 31 days from your date of hire, coverage will automatically be provided retroactive to the first day of the month in which you complete six months of net credited service as a regular full-time employee — or regular part-time employee whose actual weekly hours worked are:

- 25 or more hours a week if hired after December 30, 1980, but prior to January 1, 1990, or
- 37.5 or more hours a week if hired on or after January 1, 1990.

If you are a regular part-time employee whose coverage is not fully and automatically provided by the Company based on hours worked (as explained above) and you did not enroll for coverage within 31 days of hire, you can elect to pay for coverage after completion of six months of service. Coverage will be effective on the first day of the month following the date the Benefit Office receives your Company Enrollment Form.

Employees Hired On Or After March 1, 1990

If you did not enroll within 31 days from your date of hire,

coverage will begin automatically on the day you complete six months of net credited service as a regular full-time employee — or regular part-time employee whose actual weekly hours worked are:

- 25 or more hours a week if hired after December 30, 1980, but prior to January 1, 1990, or
- 37.5 or more hours a week if hired on or after January 1, 1990.

If you are a regular part-time employee whose coverage is not fully and automatically provided by the Company based on hours worked (as explained above) and you did not enroll for coverage within 31 days of hire, you can elect to pay for coverage after completion of six months of service. Coverage will be effective on the first day of the month following the date the Benefit Office receives your Company Enrollment Form.

Dependent Coverage
Coverage for your dependents (as defined in Section 1) will be effective on the same day as your coverage, provided you have enrolled them.

If you enroll your dependents after your coverage begins, the date their coverage would begin depends on whether or not the Company pays the full cost of their coverage as follows:

- If the Company pays the full cost of a dependent's coverage, then your dependent's coverage will be effective retroactive to the later of the date . . .

  — Your coverage began, or
  — Your dependent qualified as a dependent under MAP.

- If you are required to pay all or part of the cost of a dependent's coverage, your dependent's coverage will be effective on the date your dependent qualified as a dependent under MAP — provided you enroll your dependent within 31 days of the date your dependent qualified for coverage.

If you do not enroll your dependent within 31 days, coverage will be effective on the first day of the month after the Benefit Office receives your Company Enrollment Form.

Leave Of Absence
If you are returning from an approved Leave of Absence (other than a military leave) as a regular full-time employee and you did not continue your coverage while on leave, your coverage will begin automatically on the first day of the month following the date you return from leave provided you have already completed six months of net credited service.

Regular part-time employees whose scheduled equivalent workweek classification is less than 37.5 hours a week must re-enroll for coverage.

If you return from a military leave, your coverage will begin on the date of reinstatement, provided you return to work before loss of mandatory reinstatement rights under the law.

All dependents must be re-enrolled for coverage.

SECTION 4. COST

EMPLOYEES AND CLASS I DEPENDENTS

Full-Time Employees

Prior to March 1, 1990, if you are a regular full-time employee, the Company pays the full cost of coverage for you, your spouse and other Class I dependents beginning the first day of the month in which you complete six months of net credited service. Prior to the first day of the month in which you complete six months of net credited service, you pay the full cost if coverage is desired.

Effective March 1, 1990, the Company pays the full cost of coverage for you, your spouse and other Class I dependents beginning on the date you complete six months of net credited service. Prior to that, if you want coverage, you must pay the full cost.

Part-Time Employees

If, on or after January 1, 1990, you are either hired or re-engaged after a service break, you will be required to pay a portion of the cost of your medical coverage for any periods during which you are classified as regular part-time and during which you work less than 37.5 hours per week. The amount that you will be required to pay will be based upon the ratio of your weekly hours worked to a 37.5-hour workweek.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week or 60% of a 37.5-hour workweek), the Company will pay 60% of the cost of your coverage; either individual, two-party or family. You will be required to pay the remaining 40% of the cost.

If you were hired after December 31, 1980, and were on the payroll on December 31, 1989, your weekly cost — as long as you remain continuously employed thereafter (no service break) — for any periods in which you are classified as a regular part-time employee will be the lesser of the cost in effect on January 1, 1990, and the cost for the comparable work time under the rules in effect for the period from December 31, 1980, through December 31, 1989.

As information, scheduled hours determined the percentage paid by the Company for employees hired during the period from 1981 through 1989 based on the following schedule:

Your Weekly Work Schedule	Cost Paid By BellSouth
Less than 16 hours	0%
16 - 24 hours	50%
Greater than 24 hours	100%

If you were hired prior to January 1, 1981, this requirement does not apply to you for any period during which you are classified as a regular part-time employee after December 31, 1989, as long as your period of work has been continuous (no service break) since December 31, 1980.

Employees On Leave Of Absence

Employees on an approved Leave of Absence in excess of one month — other than a military leave — must pay the full cost if coverage is desired.

Employees On Care Of A Newborn Child/Dependent Care Leave

If the leave is an approved Care of a Newborn Child (CNC) Leave or a Dependent Care Leave which starts on or after January 1, 1990, the Company will pay the full cost of coverage for up to six months during the leave in any 2-year period — provided you were eligible to receive Company-paid coverage prior to the leave.

RETIREES AND CLASS I DEPENDENTS

Service Or Disability Pension Effective Prior To January 1, 1988

The cost of coverage for you, your spouse and for your other Class I dependents whose coverage began prior to January 1, 1988, is paid in full by the Company.

Service Or Disability Pension Effective On Or After January 1, 1988, But Prior To January 1, 1992

For those who did not retire under the Supplemental Income Protection Plan, the cost of coverage for you, your spouse and for your other Class I dependents whose coverage began before your retirement effective date is a percentage of the cost based on your years of employment as shown in the following chart:

Years Of Employment	% Of Cost BellSouth Pays	% Of Cost You Pay
30 or more	100%	0
20 - 29	90%	10%
15 - 19	80%	20%
Less than 15	70%	30%

Service Or Disability Pension Effective On Or After January 1, 1992

The cost of coverage for you, your spouse and for your other Class I dependents whose coverage began before your retirement will be paid by the Company beginning in 1993 and each year thereafter up to the 1990 actual cost level.

Your share of the cost in 1993 and each year thereafter will be the excess of the annual cost for the year two years prior to 1993 or each year thereafter over the 1990 cost plus the proration of the 1990 cost based on your years of employment as shown in the chart above. For example, the annual cost in 1993 would be determined by subtracting the 1990 cost from the 1991 cost. The 1994 cost would be determined by subtracting the 1990 cost from the 1992 cost.

Class I Dependents (Other Than Spouse) Added After Your Retirement

If you retired before January 1, 1988, you must pay the full cost of coverage for your Class I dependents (other than your spouse) added on or after January 1, 1988. The cost of coverage for a spouse added after January 1, 1988, is paid in full by the Company.

If you retire on or after January 1, 1988, you must pay the full cost of coverage for your Class I dependents (other than your spouse) added on or after your retirement. The cost of coverage for a spouse added after you retire is the same as the cost of your coverage (see chart on page 18).

CLASS II DEPENDENTS

Prior to January 1, 1991, the cost of coverage is $33.75 a month for each enrolled Class II dependent who was:

- Covered under the Medical Expense Plan (MEP) on December 31, 1987, as a Class I or Class II dependent and who then became covered under MAP on January 1, 1988, or remained covered under MEP;
- Covered under a Health Maintenance Organization (HMO) through BellSouth on December 31, 1987, and who then became covered under MAP or MEP on January 1, 1988; or
- Not enrolled in an HMO approved and offered by BellSouth on December 31, 1987 — because that HMO did not offer coverage to Class II dependents — but who became covered under MAP or MEP on January 1, 1988.

Effective January 1, 1991, the cost will change to 50% of the total cost of coverage for the Class II dependents listed on page 19.

Prior to January 1, 1991, the cost of coverage is $67.50 a month for:

- Each pre-1988 Class I dependent who is reclassified to a Class II dependent after January 1, 1988, and
- Other Class II dependents enrolled after December 31, 1987.

Effective January 1, 1991, the cost of coverage will change to 100% of the total cost for the Class II dependents listed immediately above.

SPONSORED CHILDREN

You pay the full cost of coverage for these dependents. Contact your Benefit Office for the rates.

PAYING FOR COVERAGE

If you pay for coverage, your cost for coverage will be paid as follows:

- For active employees, through payroll allotments;
- For retired employees, through pension allotments; and
- For direct bill participants, such as COBRA-covered individuals, surviving spouses, extended medical participants, etc., directly to Blue Cross and Blue Shield.

SECTION 5. HOW MAP WORKS

AN OVERVIEW

MAP pays a specified percentage of covered charges while you pay the remainder of the expenses. However, for specific types of expenses, you must first satisfy the deductible before MAP begins paying benefits.

The percentage of covered charges MAP pays depends on the way you use the Plan. To receive maximum MAP benefits, you must:

- Comply with Quality Care Program (QCP) requirements (refer to Section 6);
- Use Preferred Provider Organization (PPO) hospitals and physicians when they are available; and
- Use other cost-effective Plan features (such as outpatient surgery).

A PPO network includes hospitals, pharmacies and, effective January 1, 1991, physicians that contract with the Company to provide medical services for a discounted fee. QCP can advise you as to whether you live in a PPO area (as defined on page 9) and, if so, provide you with a listing of PPO hospitals available in your area.

The other cost-effective MAP features are explained throughout this booklet. They include, but are not limited to, receiving medical care where appropriate — such as having minor surgery performed on an outpatient rather than on an inpatient basis — and obtaining a confirming second surgical opinion when required. The following Sections of this booklet explain in more detail how these various MAP features can affect your benefit payments.

COVERED CHARGES

Covered charges (as defined on page 2) are medical expenses for treatment of a non-occupational illness or injury. The following are some of the services and expenses that are covered under MAP:

- Hospital care;
- Outpatient care;
- Physician/Surgeon care;
- Prescription drugs; and
- Certain charges for durable medical equipment.

Covered charges are also explained in greater detail in Sections 6 through 11.

INDIVIDUAL DEDUCTIBLE

In most cases, you pay the first $165 of covered expenses each calendar year for yourself and each dependent before MAP begins to pay benefits. Once the deductible requirement has been satisfied, MAP will pay a percentage of covered charges — generally 90%. However, the deductible is waived when you take advantage of certain cost-saving Plan incentives such as when certain surgical procedures are performed on an outpatient basis.

Each calendar year the deductible requirement must be met from that year's covered expenses.

FAMILY DEDUCTIBLE

Under MAP, each calendar year your family deductible will be met on the earlier of the date:

- Covered charges applied toward your deductible and/or other family members' individual deductibles total $400, or
- Two $165 individual deductibles have been met.

Once the family deductible has been met, no additional covered expenses will be applied toward any family member's individual deductible for the rest of that calendar year — even if you and your spouse are employees of different BellSouth Participating Companies. MAP will then consider future claims as if each family member has already satisfied their individual deductible requirement.

An Example

Suppose you have submitted $65 in covered charges which applied toward your individual deductible. In addition, you have also submitted covered charges totaling $150 for your son, $100 for your daughter and $85 for your spouse — all of which applied toward each person's deductible.

Since the amounts applied toward individual deductibles total $400, the family deductible has been satisfied. This means that each family member's covered charges will be processed and benefits paid as if they each had satisfied their individual deductible requirement.

The family deductible would also be met if, for example, your son and daughter each had met the $165 individual deductible.

THE PERCENTAGE PAID

Generally, after the deductible requirement is satisfied, MAP pays 90% of covered charges and you pay the remainder. However, once the out-of-pocket limit is reached (explained on page 24), or if you use MAP's cost-saving features described throughout this booklet, benefits will increase to the maximum under MAP. Hospital benefits for covered charges, excluding mental and nervous care, will increase to the MAP maximum when you use:

- A PPO hospital for inpatient and outpatient care, or
- A non-PPO hospital for inpatient and outpatient care for a Medicare-eligible participant.

INDIVIDUAL OUT-OF-POCKET LIMIT

To protect you from the catastrophic costs of a serious illness or injury, MAP places a $1,000 maximum or "out-of-pocket limit" on the amount you and each covered dependent has to pay individually each calendar year for covered charges.

Once the out-of-pocket limit of $1,000 in covered charges has been reached by you or a covered dependent, the MAP benefit level will increase to 100% for covered charges incurred for the remainder of that calendar year for that individual. However, benefits for mental and nervous conditions do not increase when the out-of-pocket limit is reached. (See Section 9 for more information.) In addition, copayments will continue to be required after the out-of-pocket limit is reached. The mental and nervous lifetime maximum of $150,000 is not affected by the out-of-pocket limit.

FAMILY OUT-OF-POCKET LIMIT

Once two family members have each reached their individual out-of-pocket limits — even if you and your spouse are employees of different BellSouth Participating Companies — MAP will pay benefits as if every covered family member has reached that limit.

EXPENSES THAT DO NOT APPLY TO THE OUT-OF-POCKET LIMIT

Some expenses do not count toward reaching the out-of-pocket limit. These include, but are not limited to:

- The $165 individual deductible or family deductible;
- Expenses not covered at all under MAP such as the Alternate Benefits (page 31) and inpatient expenses due to mental and nervous conditions when those kinds of expenses are not pre-certified by QCP;
- Expenses due to pre-existing conditions;

- Expenses not medically necessary;
- Copayments — such as for the Mail Order Prescription Drug Program and physician charges;
- Covered charges not paid by MAP because of Coordination of Benefits (COB) rules (Section 12);
- Expenses above MAP coverage limits — such as the maximum benefit limit of $150,000 for mental and nervous conditions;
- Expenses above the benefits paid by MAP for inpatient mental and nervous care (other than substance abuse care);
- Expenses over the $50 payment limit or 90% reasonable and customary charges for outpatient mental and nervous care;
- Expenses above reasonable and customary or payment allowance limits, where applicable; and
- The QCP Penalty.

PRE-EXISTING CONDITION PROVISION

Expenses due to a pre-existing condition are not covered by MAP. This provision only affects participants whose medical coverage through a BellSouth Participating Company begins on or after January 1, 1988.

A "pre-existing condition" is an illness or injury, including pregnancy, for which you or a dependent received treatment (including, but not limited to, medication) during the 90 days prior to the effective date of coverage.

An illness or injury will no longer be considered a pre-existing condition under MAP when:

- No treatments have been received for the pre-existing condition during six consecutive months of coverage under MEP or MAP, or

- MEP and MAP coverage on the participant with the pre-existing condition has been in effect for 12 months.

THE HEALTH MAINTENANCE ORGANIZATION OPTION

Each year you will be given the choice to continue coverage under MAP or to elect coverage through a Health Maintenance Organization (HMO) approved and offered by the Company in the area in which you live.

You may also enroll in an HMO within 31 days of:

- Your initial employment or reinstatement to active employment;
- The date you moved into a new service area; or
- Your pension effective date.

In addition, your eligible dependents may enroll or re-enroll in an HMO according to that HMO's rules — provided you are enrolled in that HMO.

If an HMO is available to you — and you elect it for you or for you and your dependents — the Company is currently contributing up to the same amount as it would toward the cost of your coverage under MAP. Any additional costs — based on the enrollment costs established by that HMO — will be paid by you through payroll or pension allotments.

MAP LIFETIME BENEFIT MAXIMUM

Generally, while you are an active employee, there is no overall lifetime benefit maximum to the amount of benefits payable under MAP for you or your dependents. However, certain benefits, such as for mental and nervous care, have specific limits as described throughout this booklet.

A $1,000,000 individual lifetime benefit maximum does apply to:

- Retirees and their dependents beginning on the first day of the year following retirement;
- LTD eligibles and their enrolled dependents on the first day of the year following eligibility for LTD benefits; and
- Dependents of deceased active employees with surviving spouse benefits beginning on the first day of the year following the date each surviving dependent (including the spouse) reaches age 65.

SECTION 6. THE QUALITY CARE PROGRAM

The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care according to MAP provisions while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay continues to be certified under MAP.

QCP also helps by telling you if your maternity charges or other surgeon's charges are within MAP's coverage limits. For QCP to do this, you must provide the physician's Current Procedural Terminology (CPT) code.

* * * * * *

When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor.

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HOW TO CONTACT QCP

To contact QCP, call **1-800-541-2234**, toll-free. To save time, it is recommended that your physician contact QCP. However, you, a family member or a friend may contact QCP on your behalf.

WHEN TO CALL QCP

There are certain circumstances when QCP must be contacted if you are to receive maximum MAP benefits as explained on the following page.

When MAP is the primary plan, QCP **pre**-certification is required for:

- Overnight hospital admissions;
- Inpatient surgeries;
- Mandatory Outpatient Surgical Procedures performed on an inpatient basis (page 44); and
- Surgical procedures on the Mandatory Second Surgical Opinion List (page 47).

QCP certification is required within 48 hours of any emergency hospital admission if the stay is expected to last longer than 48 hours.

Whether MAP is the primary or secondary plan, even if you or your dependents are Medicare eligible, to be a covered expense, QCP pre-certification is always required for:

- Inpatient mental and nervous care expenses;
- Alternate Benefits; and
- Private duty nursing (page 63).

Rules for determining when MAP is the primary or secondary plan are explained in Section 12.

Call QCP for a list of PPO hospitals. In addition, QCP can provide telephone numbers of PPO hospitals so that you can obtain the names of physicians who have admitting privileges at those PPO hospitals.

QCP certification is not required for surgery or hospitalization outside of the continental United States.